No. 89-1044

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., *et al.*,
Petitioners,

v.

BLUE CROSS AND BLUE SHIELD OF RHODE ISLAND,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the First Circuit

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BRIEF OF GROUP HEALTH ASSOCIATION OF AMERICA, INC. AS AMICUS CURIAE IN SUPPORT OF THE PETITIONERS

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INTEREST OF AMICUS CURIAE

Pursuant to Rule 37 of the Rules of this Court, Group Health Association of America, Inc. ("GHAA") files this brief as *amicus curiae* in support of the petition for writ of certiorari.[1]

GHAA, founded in 1959, is the largest national trade association of health maintenance organizations ("HMOs"). Its 270 member HMOs provide health benefits coverage for over 21 million people in the United States. GHAA's members include independent locally-based non-profit and for-profit plans, as well as HMO programs operated by national HMO firms, subsidiaries of Blue Cross and Blue Shield plans, and subsidiaries of major insurance organi-

[1] Letters of consent from the parties have been lodged with the Clerk of the Court.

zations.[2] Many are "qualified" under the federal Health Maintenance Organization Act, 42 U.S.C. §§ 300e-300e-17.

GHAA's member HMOs provide or arrange for health services in a number of ways. Some employ staff physicians. Some have contracts with medical group practices or associations of individually practicing physicians. Some contract directly with individual physicians. Others use a combination of these methods. All, however, provide or arrange for health care services through an established network of contracting physicians, in contrast to traditional indemnity benefit plans that cover services by all or almost all of an area's health care providers. Many HMOs use a "primary care physician" or "gatekeeper" approach to manage health care and help control its cost, whereby the member's family physician must give advance approval for referrals to specialists and hospitals. Risk-sharing arrangements are often used with physicians to encourage cost-efficient care. These may be "capitation" methods or a "withhold" system such as that used by petitioner Ocean State Physicians Health Plan ("Ocean State").

HMOs have historically faced the difficulty of entering and competing in health care financing markets historically dominated by health plans and insurers operating on a traditional indemnity basis, and have struggled with the long ingrained hostility to prepaid closed panel medical practice among segments of the medical community. *See, e.g., American Medical Ass'n v. United States*, 317 U.S. 519 (1943); *American Medical Ass'n*, 94 F.T.C. 701 (1979), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd per curiam by an equally divided Court*, 455 U.S. 676 (1982); *Medical Service Corp. of Spokane County*, 88 F.T.C. 906 (1976) (consent agreement). Because HMO members use the services of a limited panel of pro-

[2] Petitioner Ocean State Physicians Health Plan is not a member of GHAA. HMO Rhode Island, an affiliate of the respondent, is a member of GHAA.

viders who have agreed to negotiated price and medical review terms with the plan, HMOs have long posed a competitive threat to physicians practicing on the traditional "freedom of choice" fee-for-service basis, and to indemnity health plans and insurers whose reimbursement programs are structured to cover the services, and price structures, of substantially all the providers in a community.

HMOs entering a market dominated by one or more traditional indemnity benefits carriers must recruit an adequate panel of physicians to appeal to employers and potential subscribers. They must contract with these physicians to control the price and unnecessary utilization of health services, the critical determinants of the HMO's input costs. Once in operation, HMOs provide needed stimulus to health care markets where comprehensive insurance coverage makes most individual consumers relatively insensitive to price differences among providers, and the traditional "freedom of choice" insurance reimbursement environment has given little incentive to physicians to lower their fees.

HMOs have now achieved substantial success in many areas of the country. Consumers have responded favorably to the comprehensive benefit programs and high quality of care HMOs make available at rates that are commonly lower than traditional indemnity programs. The traditional indemnity payors are responding. Some are developing their own innovative programs and HMO operations. Others are trying to use their power to blockade the market and prevent HMOs from competing effectively.

Respondent Blue Cross and Blue Shield of Rhode Island ("Blue Cross") covered the majority of Rhode Island's private paying patients and had contracts with 90% of the physicians. It had monopoly power. With the stated purpose of sending a message to every physician in the state on the "implication of signing" with Ocean State and thereby, to paraphrase Blue Cross's president, castrate the HMO, Blue Cross declared that it

would reduce each physician's reimbursement to the lowest level charged by that physician to another payor. Describing this program as its "Prudent Buyer" policy, Blue Cross characterized as a 20% discount the withhold arrangements used by Ocean State as part of its risk-sharing and cost control incentive plan with its doctors.

The Ocean State doctors, especially those whose Blue Cross patients greatly outnumbered their Ocean State patients, were caught in an economic vise. Even though Ocean State was a well-positioned entrant, with sponsorship and ownership by its participating physicians, over a fourth of the HMO's doctors quit. It was forced to incur higher costs paying non-contracting physicians for services that would otherwise have been performed by physicians under contract to the HMO. Its panel of participating physicians, a key competitive attribute for HMOs in appealing to consumers, was significantly diminished.

At the same time, Blue Cross pressured employers not to deal with Ocean State. Most employers will not arrange solely for HMO coverage for their employees and their dependents because many beneficiaries are accustomed to having free choice of physician in their health plan and do not desire HMO coverage. In Rhode Island, moreover, Blue Cross's market power was reflected in the belief among many employers that they needed to offer Blue Cross coverage as an option for their employees, even if they offered alternative HMO coverage. Blue Cross exploited this power by adopting a policy of price discrimination, charging arbitrarily high premiums to employees who offered HMO coverage in addition to Blue Cross.

HMOs across the country are facing practices similar to those at issue in this case. Doctors who agree to participate in low cost HMOs are threatened with reduced reimbursement by powerful health carriers operating on the traditional indemnity insurance model. Some carriers are refusing to provide coverage to employers who also purchase HMO coverage. Others are willing to

provide coverage if the employer continues to offer HMO coverage, but will only do so at much higher rates than would otherwise be charged.

These practices can be legitimate competition on the merits when employed in a competitive market. However, their use by a monopolist can be devastatingly anticompetitive and without reasonable justification. The danger to competition in private health care financing markets is significant, posing the risk that the procompetitive stimulus HMOs provide will be stifled in those markets where competition is most needed.

The court of appeals affirmed the trial court's overturning the jury verdict that Blue Cross had engaged in monopolization. It held that Blue Cross's policy of reducing reimbursement to doctors participating in Ocean State, as a matter of law, was not exclusionary. It also held that discriminatory pricing by Blue Cross was not coercion and therefore was exempt from antitrust scrutiny as the state-regulated "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. §§ 1012(b), 1013(b). The court's antitrust analysis was fundamentally unsound and invites similar anticompetitive conduct harmful to HMOs and to consumers in other health care markets across the country.

REASONS FOR GRANTING THE WRIT

I. INTRODUCTION

This case presents two issues critical to antitrust jurisprudence generally and to the vitality of competition in health care financing and delivery. First, the case presents a significant opportunity for the Court to address application of Section 2 of the Sherman Act, 15 U.S.C. § 2, to the use of a monopolist's market power to drive up the input costs of a new rival, where the monopolist's conduct also reduces its own costs. Second, it provides the Court a chance to resolve what conduct in the business of insurance constitutes "coercion" and is therefore subject to the Sherman Act, notwithstanding the anti-

trust immunity provided by the McCarran-Ferguson Act, 15 U.S.C. §§ 1012(b), 1013(b).

II. THE COURT BELOW GAVE IMPROPER CONCLUSIVE EFFECT TO THE EXISTENCE OF COST SAVINGS FOR BLUE CROSS

The court of appeals' construction of Section 2 would permit a monopolist, *as a matter of law*, to secure its monopoly position through any competitive conduct that saves the monopolist money, regardless of its effect on consumers and competitors and in utter disregard of the availability of less restrictive alternatives and of the monopolist's stated intention to destroy its competition by raising a competitor's costs. This ruling tips the balance in Section 2 analysis far beyond giving due consideration to legitimate efficiency-enhancing effects of a monopolist's market behavior. Instead, it improperly creates a virtual *per se* rule of legality, making the existence of any efficiency justification a complete defense for exclusionary conduct.

Blue Cross is a monopolist in the Rhode Island health care financing market. It has participation contracts with more than 90% of the practicing physicians in the state. It covered a great majority of the privately insured population. Petitioner Ocean State was a new entrant HMO seeking to compete against Blue Cross's dominance. It needed to secure and maintain participation agreements with a limited, but sufficient-sized, panel of physicians who would agree to reimbursement and utilization management terms that would permit the HMO to price its health care coverage competitively with Blue Cross.

One means used by Ocean State and other HMOs to control costs is to include "withhold" and "bonus" provisions in their contracts with participating physicians. Under these arrangements, a portion of the physician's fee is withheld, but returned by the HMO if its budget allows once expenses for the year are calculated. In

addition, under Ocean State's specialty incentive pool program ("SIPS"), which commenced before the Prudent Buyer program went into effect, any savings from budget allocations for expenses in each of the various medical specialties are also payable as bonus distributions to the specialists.

These devices serve two purposes. They give the participating physicians incentives, absent in the traditional fee-for-service system, to control unnecessary utilization of health care services. Further, availability of the withhold to offset higher than expected health care costs permits the HMO to reduce its net expenses.

After Ocean State had made inroads into Blue Cross's market share and Blue Cross had incurred some financial losses, Blue Cross decided to strike back. It adopted a "Prudent Buyer" policy under which payments to a physician would be reduced to the lowest fee charged by the doctor to any other payor. Blue Cross treated the "withhold" reductions by Ocean State as a discount, so it announced it would reduce fees payable to Ocean State doctors by 20%.

Ocean State's physicians faced the unhappy prospect of receiving 20% less for their services for the bulk of their patients (those covered by Blue Cross) or giving up the lesser number of patients they covered through Ocean State. Where Ocean State members were a small percentage of a doctor's practice, the economic pressure on the physician to quit Ocean State was severe. A quarter of them did quit, resulting in Ocean State having to pay for services from non-participating physicians at much higher rates than it had previously paid participating physicians. This hindered Ocean State's efforts to diminish Blue Cross's market dominance through vigorous price competition in premiums beneficial to consumers.

The "Prudent Buyer" policy was adopted, according to the Blue Cross official responsible for its implementation, to send a message to every doctor in the state

about the financial implications of contracting with Ocean State. It was adopted, as the court below paraphrased Blue Cross's president, to literally "emasculate" Ocean State. Pet. 24a.

The jury found that Blue Cross had engaged in monopolization. The trial judge granted judgment notwithstanding the verdict, and the court of appeals affirmed.

A. The Court of Appeals Misapprehended or Grossly Misapplied the Proper Standard For Assessing Whether Blue Cross's Prudent Buyer Policy Was Exclusionary by Failing to Consider Whether the Policy Was Unnecessarily Restrictive of Competition.

Section 2 of the Sherman Act condemns the "willful" maintenance of monopoly power. *See United States v. Grinnell Corp.*, 384 U.S. 563, 570-71 (1966). This "willfulness" standard requires that monopolizing conduct be "exclusionary," which the court below defined as behavior that:

> not only (1) tends to impair the opportunities of rivals, but also (2) either does not further competition on the merits or does so in an unnecessarily restrictive way. Pet. 18a.

See Aspen Skiing Co. v. Aspen Highlands Skiing Corp., 472 U.S. 585, 605 n.32 (1985), *quoting* 3 P. Areeda & D. Turner, *Antitrust Law* ¶ 626b at 78.

The court did not contest that the evidence permitted a conclusion that the Prudent Buyer policy did tend to "impair the opportunities" of Ocean State. Nevertheless, it concluded that Prudent Buyer was a "bona fide policy to ensure that Blue Cross would not pay more than any competitor paid for the same services." Pet. 18a. Such a policy, the court found, "tends to further competition on the merits and, *as a matter of law*, is not exclusionary." Pet. 19a (emphasis added).

The court jettisoned the very standard for identifying "exclusionary" conduct that it had enunciated, that be-

havior which furthers "competition on the merits" can be exclusionary if it does so "*in an unnecessarily restrictive way.*" (emphasis added). The court's analysis abandoned this critical component of the standard. Scrutiny of a practice's effects and character under Section 2 cannot cease merely upon finding that conduct reduces the monopolist's costs and thereby theoretically furthers "competition on the merits."

Following the reasoning adopted by the court below, a monopolist could lawfully force all the suppliers in a market to sign exclusive contracts if this would assure responsive service and achieve other benefits that would save it money. Similarly, a monopolist might decide that acquiring its only competitor would achieve some incremental savings. Section 2 does not sanction such conduct by a monopolist merely upon a showing that the conduct reduces the monopolist's costs and thereby furthers competition on the merits.

Rather, sound antitrust analysis would plainly require, if such practices were not condemned outright, that the exclusionary character of those actions be assessed taking into account both their anticompetitive and procompetitive aspects. Once the practices were shown to impair the opportunities of the monopolist's competition, any procompetitive efficiency benefits would be considered in light of long-term effects on consumers and of alternative means of cost-saving open to the monopolist that would be less restrictive of competition. The court could, moreover, properly rely on intent evidence to inform its judgment about the exclusionary character of challenged conduct.[3]

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[3] Application of Section 2 analysis in this manner would be consistent with the approach under the rule of reason set forth by this Court for Sherman Act, Section 1 matters. *See FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1985); *Nat'l Collegiate Athletic Ass'n v. Board of Regents of Univ. of Okla.*, 468 U.S. 85 (1984); *Broadcast Music, Inc. v. Columbia Broadcasting Sys.*, 441 U.S. 1 (1979).

The court of appeals did not explore whether the jury could have reasonably found that Blue Cross had sufficient alternative means of reducing its costs in response to Ocean State's competition. Nor did the court assess whether the policy was unnecessarily restrictive of competition by weighing the practice's procompetitive benefits against its anticompetitive effects. The court focused on Blue Cross's cost savings in those instances where doctors remained in both programs, but gave no weight to the fact that the Prudent Buyer policy induced doctors to quit Ocean State. These resignations, foreseen and intended by Blue Cross, drove up Ocean State's costs without reducing Blue Cross's.

Instead, the court below reformulated the issue. The court stated, "Even a monopoly can engage in a competitive course of conduct, so long as it does so for valid business reasons (such as the desire to get the lowest possible price), rather than in order to smother competition." Pet. 21a. This formulation ignores the "unnecessarily restrictive" of competition component of the analysis and precludes balanced assessment of the competitive effects of the monopolist's conduct. Apart from a circular and unsound analysis of the intent evidence, the court's consideration of the character and competitive effects of Blue Cross's conduct effectively ceased with its observation that the Prudent Buyer policy was an effort to reduce Blue Cross's costs.

B. The Court of Appeals Misapprehended the Role of Intent Evidence in Determining Whether Blue Cross's Conduct Was Exclusionary.

The court indicated that "competitive" conduct by a monopolist is permissible regardless of its effect on the competition, so long as it is engaged in for "valid business reasons" and not to "smother competition." Pet. 21a. The court sought to overcome striking evidence that the Prudent Buyer policy had been adopted with the knowledge and intent that it would harm—indeed emasculate—Ocean State by driving up its input costs. The court explained away this evidence, insisting that

the intention to make a competitor "disappear" is "irrelevant" so long as the conduct is "legitimate." Pet. 24a. The court reasoned further that lowering Blue Cross's costs was, *ipso facto*, legitimate and therefore that the Prudent Buyer policy was supported by valid business reasons. The result of this circuitous inquiry was that the "desire to crush a competitor," Pet. 24a, would not be relevant in determining whether the monopolist intended to "smother competition." Pet. 21a.

The court was correct, of course, that an intention to prevail over, or destroy, one's competition is not evidence of anticompetitive intent or invalid reasons for competitive conduct. The court lost its way in this discussion, though, by failing to focus on *how* Blue Cross as a monopolist intended to crush its competition—by reducing its own costs so it could charge lower premiums, or by raising Ocean State's costs. If Blue Cross intended to defeat Ocean State through reduced premiums after it had reduced its own expenses, the court's reasoning on this point might not have been so far off the mark. In fact, Blue Cross did not reduce its premiums.

Rather, the actual and intended harm to Ocean State was increased costs and reduced appeal to consumers caused by resignation of so many of its participating physicians. Apart from its president stating in colorful language that Blue Cross intended to castrate Ocean State, the Blue Cross official charged with implementing the Prudent Buyer program had emphasized that "not one guy *in the state isn't going* to know the implication of signing with Ocean State." Pet. 24a (emphasis in original). The jury quite properly relied on the direct and inferential evidence of Blue Cross's intent in concluding that the predominant character of the Prudent Buyer policy was to suppress competition.

C. The Prudent Buyer Policy Was Not a Means to Achieve the Same Low Price Charged to a Competitor.

Ocean State's purchasing arrangements with physicians provided for initial payments to the physicians at

a lower rate than Blue Cross was paying, since a percentage of the fee payable to the doctor was withheld by Ocean State. From an economic and antitrust analysis standpoint, that reduction was not a true 20% price discount.

First, in any given year, some or all of a physician's withhold might be returned to him. Second, under the Ocean State SIPS program put in place before the Prudent Buyer program went into effect, the doctors were also eligible to receive bonus payments from Ocean State in addition to return of their withhold fees if the HMO achieved adequate savings on health care costs in their specialty. Thus, the withhold arrangements were the flip side of an "upside" potential for the doctors. Third, the doctors were the shareholders of Ocean State, so that any profits from its operations would inure to their benefit. Finally, doctors might be willing to give a lower price to Ocean State than to Blue Cross in the hope that Ocean State would eventually erode Blue Cross's market share and produce a more competitive health care financing market. This would result in more competition for their services, and a better price and quality package for consumers. While the compensation arrangements the physicians had with Ocean State would presumably have met their marginal costs for the extra patients brought to them by the HMO, even if they never received their withheld fees, reimbursement at a 20% lower rate by Blue Cross could well have resulted in insufficient overall practice revenues for some Ocean State doctors to cover their total costs.

Thus, Blue Cross's blanket reduction of 20% from the fees payable to Ocean State physicians did more from an economic standpoint than ensure that it paid as low a price as Ocean State. It gave those physicians an even lower effective price than the effective price paid by Ocean State.

D. The Court of Appeals Erred in Declaring That the Prudent Buyer Policy Could Not Be Exclusionary if Blue Cross's Payments to Physicians Were Not "Predatory" or "Below Cost."

The court of appeals found that so long as the price being paid to the doctors was not "predatory" or "below cost," the Prudent Buyer policy could not be exclusionary. Pet. 19a. This incorporation of monopoly pricing principles into an assessment of Blue Cross's monopoly purchasing behavior was erroneous. Predatory pricing theory deals with below-cost sales to customers that a monopolist's weaker competitors cannot afford to match. The analogy in monopoly purchasing would be a firm paying a price to its suppliers that was so high that the purchaser could only recoup its costs if it could sell at monopoly prices in the long run by drying up the sources of supply to its competition.

Traditional predatory pricing (or buying) analysis, however, is inappropriate here. Blue Cross was not necessarily paying excessively high prices to suppliers to foreclose their availability to competitors. This monopolist was punishing suppliers for giving perceived discounts to the competition. That the monopolist might save money in doing so is no absolute defense.

Predatory below-cost pricing by a monopolist, whatever standard for application of that label is adopted, is presumptively anticompetitive because the prices being charged are so low as not to make business sense absent an exclusionary effect that will permit the perpetrator to later recoup its costs through an exercise of monopoly power. Thus, there is no need to balance the particular procompetitive and anticompetitive effects of the practice once pricing has been determined to be predatory. It is for this reason that the standard of proof to establish predatory pricing is so high, and why there has been so much debate in the case law and academia on its true parameters.

Here, in contrast, there is no predatory pricing (or, by analogy, "predatory buying" at high prices to foreclose supply). Thus, it is critical to make the competitive effects analysis that the standard articulated by the court below calls for, but which the court failed to do—determining whether the "competition on the merits" that impairs opportunities of competitors is unnecessarily restrictive of competition. A plausible or colorable efficiency justification for a challenged practice removes the conclusive presumption of illegality that applies to truly predatory pricing, but does not mark the end of the analysis of competitive effects. This Court has never ruled that the presence of any efficiency justification is sufficient to make *per se* lawful a monopolist's practice which injures competitors. *Cf. Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 604 (1985) (business success that "reflects *only* a superior product, a well-run business, or luck" is not monopolization) (emphasis added).

E. The Prudent Buyer Policy Was Unnecessarily Restrictive of Competition.

In a competitive market, one buyer might contract with a supplier to adjust the price if the supplier sells to another buyer at a lower price. The buyer and seller in the competitive market are incapable of affecting or dictating the "market" price. The inclusion of a "lowest price" clause in the contract can be a means of ensuring to the extent possible, given changes in the market over time and lack of perfect information when the contract is signed, that their transactions are conducted at the "market price."

A buyer with market power, in contrast, has the power to set price.[4] Such a buyer has no comparable

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[4] There is solid evidence here that Blue Cross had market power not only as a seller of health coverage, but also as a purchaser of physician services. For example, Ocean State doctors faced with the loss of Blue Cross's subscribers would find it extremely hard

need to adapt its business dealings to the market. Its actions can determine the market price. It can protect itself from overcharge through exercise of its own purchasing power. It can force below competitive levels of payment on its suppliers if it so chooses.

Indeed, Blue Cross had a multitude of choices. For example, it could have determined what level of fee reductions it needed to reduce costs and compete more effectively with Ocean State. It could then have directly sought such price reductions from its physician suppliers, without tying the price reduction to whether the individual doctor was charging a particular price to Ocean State or anyone else.

Blue Cross may have already exploited its available power to require physicians to provide the lowest price that Blue Cross could reasonably require, without degrading the quality of the service the doctors provided below a level satisfactory to Blue Cross and its customers. Commencing to pay them less would be "predatory" as to the physicians. If that was the situation when Blue Cross imposed the Prudent Buyer policy, it was using its power to force at least some of its suppliers to raise their price to, or cease dealing with, Ocean State.[5]

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to compete in any realistic time period for enough additional patients to replace them. Most other patients are covered by governmental or commercial health benefit programs that will reimburse any provider. Since fees payable are either regulated or paid almost in full by the payor, reduction in fees is not normally a viable means for a doctor to attract substantial numbers of new clients, other than through contracts with managed care plans such as HMOs which cover only a limited portion of the population. Doctors who continued with Ocean State risked losing a great portion of their practice income with no prospect of quick recoupment.

[5] If Blue Cross was already paying a monopsony price, then its insistence on cutting the rates by 20% for those contracting with Ocean State would appear presumptively unreasonable in its effects on Ocean State.

Or, as petitioners have suggested, Blue Cross may have been paying its physician contractors more than it needed to. In that case, its failure to directly seek price reductions across the board from its participating physicians in response to competition from Ocean State itself manifests selection of a policy that would obstruct Ocean State's efforts to lower its costs, and rejection of a simple strategy that would have served more directly to reduce Blue Cross's own costs. Blue Cross's strategy saved it money for services by doctors who stayed with Ocean State, but served only to raise Ocean State's costs with respect to the many doctors who Blue Cross could foresee would, and in fact did, quit Ocean State.[6]

There may, no doubt, be economic theories which could be articulated that would purport to vindicate the course Blue Cross elected as enhancing competition. Here, though, Blue Cross's exercise of market power was anti-competitive and unreasonable by the standard logic of antitrust law and economics, since it was an attempt to exclude a rival "on some basis other than efficiency." *See Aspen Skiing*, 472 U.S. at 605. In any event, the court of appeals erred in concluding that a reasonable jury, as a matter of law, could not find that the record established exclusionary conduct.

III. THE COURT OF APPEALS TOO NARROWLY CONSTRUED THE EXCEPTION FROM ANTITRUST IMMUNITY UNDER THE McCARRAN-FERGUSON ACT FOR ACTS OF COERCION

Part of Blue Cross's strategy to destroy its competition was a price discrimination scheme. Employers who chose to buy coverage from both Ocean State and Blue Cross were charged arbitrarily higher premiums by Blue

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[6] Indeed, if doctors had not quit Ocean State, but all (or all but a few) had agreed to lower their prices to Blue Cross, there would be no monopolization here. There would merely be a procompetitive reduction in costs. Blue Cross knew, and the economics of the market dictated, that a large number of the doctors would not stay in both programs and would quit Ocean State.

Cross than those who dealt only with Blue Cross.[7] Blue Cross could impose arbitrary premium differentials because of its market power. Rhode Island employers commonly feel they have to offer Blue Cross even if they also offer HMO coverage. Although price differentials based on a health plan's degree of penetration in an employer account can be competitively reasonable and actuarially justified, their use here by Blue Cross was unjustifiably coercive and anticompetitive.

The court below found that Blue Cross's pricing discrimination was exempt from antitrust scrutiny under the McCarran-Ferguson Act, notwithstanding the exception from immunity under that Act for acts of "coercion." 15 U.S.C. § 1013(b). Since its passage in 1945, the McCarran-Ferguson Act has been the subject of numerous court battles regarding its scope in exempting conduct from antitrust scrutiny. This Court has repeatedly emphasized that this exemption from the antitrust laws is to be narrowly construed. *See, e.g., Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1981); *Group Life and Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).

In *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 541 (1977), this Court made clear that the exception from McCarran-Ferguson Act immunity for "boycotts" was to be construed consistent with the traditional meaning of the term boycott in antitrust jurisdiction. Although little precedent has arisen regarding the scope of the exception from McCarran-Ferguson Act immunity for "acts of coercion," the same approach for construing the term "coercion" should apply.

The court below found that the price differentials imposed by Blue Cross were not coercion. It said the record lacked evidence that any employer was coerced not to

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[7] It involved in this scheme a Blue Cross subsidiary HMO evidently established without prospects for its own business success, but which would be used in undermining Ocean State.

offer Ocean State to its employees. Pet. 16a. The court discounted evidence regarding one employer by pointing out that Blue Cross's actions did not leave the employer with "no choice." Pet. 16a. The court continued, "He merely faced rate increases that were somewhat greater than they otherwise would have been." The court applied an erroneous standard in assessing whether the record established coercion.

Congress chose to use the phrase "acts of . . . coercion" in the McCarran-Ferguson Act, and not "refusals to deal" or "exclusive dealing." Unilateral insistence that a customer either do business with the offeror or with a competitor, but not with both, is generally neither coercive nor anticompetitive when employed by a firm without market power. Thus, for example, a tie-in arrangement is not "coercive" where there is no market power. *See Jefferson Parish Hosp. Dist. Number 2 v. Hyde*, 466 U.S. 2 (1933). "Coercion," in contrast, connotes forced imposition of terms of dealing through exertion of economic power. This could obviously reach a great many things done by a monopolist, but that is no reason to adopt a narrower construction of the term.

Petitioners have suggested "coercion" could be construed to reach only coercive *anticompetitive* conduct. Pet. 25. Such a reading is narrower than necessary. Thus, a monopolist might threaten to refuse to deal with a customer unless it agreed to pay the monopolist's high prices. This could be coercion, but it would not be anticompetitive, since it would not maintain the monopolist's market power and thus would not violate any provision of the antitrust laws. There is no reason, though, to construe the "coercion" exception from McCarran-Ferguson Act immunity as only applying to conduct unlawful under the Sherman Act. As this Court stated in *Pireno*, "It is axiomatic that conduct which is not exempt from the antitrust laws may nevertheless be perfectly legal." 458 U.S. at 126 (*quoting Group Life and Health Ins. Co. v. Royal Drug Co.*, 440 U.S. at 210 n.5).

Where a monopolist uses its power to force customers to choose between even higher prices and refusing to purchase from any other supplier, this conduct can be as coercive as if the monopolist had simply threatened to refuse to deal altogether with customers who continue to purchase from any other supplier. Identifying an absolute refusal to deal as coercion, but not the equally threatening imposition of disadvantageous trade terms on the customer who chooses not to deal exclusively with the monopolist, is to miss the essence of coercion's meaning in economic terms.

The critical inquiry in determining whether conduct is coercion is to determine if its imposition involves an exercise of market power. If the pricing differentials in fact were actuarially justified, for example, then their use would not have been a manifestation of market power. Whether there was sufficient evidence to show that the price differentials were so unjustified as to be coercive and monopolistic is a question to be determined on the basis of the record, in accordance with an appropriate legal standard. That legal standard should not be an insistence that the target employer must have been left without any choice in the matter.

It is no refutation of the existence of monopoly power or of its coercive exercise that a customer could choose to deal with others rather than the monopolist, at great added expense. Given the finding that Blue Cross had monopoly power, the court of appeals committed plain error in holding that charging unreasonably discriminatory prices to customers who will not deal exclusively with the monopolist could not be found to be coercion.

CONCLUSION

The decision of the court of appeals sets an extremely damaging precedent in the field of health care and in antitrust law generally. That court's decision provides sweeping exculpation of anticompetitive conduct by a monopolist so long as the conduct saves the monopolist

money, regardless of the conduct's anticompetitive effects, long-term injury to consumers, the monopolist's intent to destroy competition by forcing increases in a competitor's costs, and the existence of alternative means of cost reduction for the monopolist. The decision also applies an erroneous standard for determining whether conduct by a monopolist, short of an absolute refusal to deal, can be found to be "coercion" outside the scope of the McCarran-Ferguson Act antitrust exemption.

Unless reviewed by this Court, this decision will provide comfort and reassurance to other firms in the health care delivery and financing industry engaging in similar behavior. The resulting loss of competition will be manifested in higher prices and lower quality of health care benefits in the future. The writ of certiorari should be granted to review the judgment of the United States Court of Appeals for the First Circuit.

Respectfully submitted,

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